

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MAR 18 2002

1. TRANSMITTAL NUMBER:  
**02-002**

2. STATE  
Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
January 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 (\$1,513,500)

b. FFY 2003 (\$3,661,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B

Pages 1a through 1c, Page 7b, Page 8, and page 9 through 9b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-B

Pages 1a through 1b, Page 7b, Page 8, and page 9 through 9b

10. SUBJECT OF AMENDMENT:

Rates – rural health clinics and federally qualified health centers

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

DENNIS BRADDOCK

14. TITLE:

Secretary

15. DATE SUBMITTED:

3-13-02

16. RETURN TO:

Department of Social and Health Services

Medical Assistance Administration

623 8<sup>th</sup> St SE MS: 45500

Olympia, WA 98504-5500

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

MAR 18 2002

18. DATE APPROVED:

MAR 23 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JAN 1 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

151

21. TYPED NAME:

Banner Baffield

22. TITLE:

ASSOCIATE REGIONAL ADMINISTRATOR  
DIVISION OF MEDICAID

23. REMARKS:

3/15

Olympia  
CITY/STATE

Changes authorized by me sent on 5/15/02

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Washington

## B. Rural Health Clinics (continued)

Effective January 1, 2001, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all RHCs that provide services on or after January 1, 2001 and each succeeding year are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an RHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the clinic that is at least equal to the PPS payment rate. This alternative methodology must be agreed to by the State and each RHC, and documentation of each clinic's agreement must be kept on file by the State. If an individual RHC does not agree to be reimbursed under this alternative methodology, the RHC will be paid under the BIPA PPS methodology. Effective for dates of service January 1, 2001 through December 31, 2001, each RHC agreed to an alternative methodology that provided payments at least equal to the amount the clinic was entitled to under BIPA PPS. Effective for dates of service on and after January 1, 2002, the State fully implements the PPS methodology as described in BIPA 2000.

Using the PPS methodology, the payment is set prospectively using a weighted average of 100 percent of the clinic's total reasonable costs for all Medicaid-covered services as defined in the State Plan for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during calendar year 2001 to establish a base encounter rate. A clinic may choose to allocate applicable costs and encounters to specific services such as dental, mental health, etc., and establish a separate encounter rate for these services. A base encounter rate for these services will be set in the same method. The encounter rates are determined using Medicare's audited cost reports and each year's rate is weighted by the total reported encounters. The formula used to calculate the base encounter rate is as follows:

$$\text{Base Encounter Rate} = \frac{(1999 \text{ Rate} * 1999 \text{ Encounters}) + (2000 \text{ Rate} * 2000 \text{ Encounters})}{(1999 \text{ Encounters} + 2000 \text{ Encounters})}$$

TN# 02-002  
Supercedes:  
TN# 01-009

Approval Date:

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Washington

## B. Rural Health Clinics (continued)

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service shall occur if: (1) the clinic adds or drops any service that meets the definition of RHC service as defined in section 1905(a)(2)(B) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment. The clinic is responsible for notifying the RHC Program Manager in writing of any changes during the calendar year no later than 60 days before the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change in scope of service. If the change represents a decrease in scope of service the State will recalculate the base encounter rate by decreasing it by the average cost per encounter detailed in the clinic's 1999 and 2000 cost reports. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost per encounter as detailed in the 1999 and 2000 cost reports from other clinics that provide the service. This interim rate will be effective the date the new service is implemented and fully available to Medicaid clients. Once the clinic can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary and adjust the interim rate by the accepted cost per encounter to establish a final encounter rate.

Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the clinic's scope of services. The MEI for primary care services will be applied to all types of encounter rates established for the clinic.

Rural Health Clinics receiving their initial designation after January 1, 2001 will be paid an average encounter rate of other clinics located in the same or adjacent area with a similar case load on an interim basis until the clinics' first audited Medicare cost report is available. Once the audited report for the clinic's first year is available, the new RHC's encounter rate will be set at

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## B. Rural Health Clinics (continued)

100% of its costs as defined in the cost report. The new RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available and will receive the MEI increase each year thereafter using the defined methodology.

For clients enrolled with a managed-care contractor, the State will pay the clinic a supplemental payment on a per member per month basis, in addition to the amount paid by the managed-care contractor to insure the clinic is receiving the full amount it is entitled to under the PPS methodology. ~~The supplemental payment will be the average of the clinic's 1999 and 2000 supplemental payments. Beginning January 1, 2002 and each year thereafter, the supplemental payment will be increased by the MEI for primary care services.~~

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The supplemental payment is the difference between the payments the clinic received from the managed-care contractor and the payments the clinic would have received under the PPS methodology. This supplemental payment will be paid at least every four months.

Until the State obtains final audited cost reports for 1999 and 2000 for all RHCs, and establishes final base encounter rates, the clinics will be paid using an interim encounter rate comprised of the most current available cost information. The State will perform a reconciliation and settle any overpayments or underpayments made to the clinics retroactive to January 1, 2002.

Medicaid-Medicare patients will be reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

- C. Clinic services in comprehensive outpatient rehabilitation facilities will be paid the lesser of Medicare's upper payment limits or the department's fee schedule.

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XIV HOSPICE SERVICES

Payment is made to a designated hospice provider based on a daily rate. The rates are contingent on the type of service provided that day. The rates are based on the Medicaid guidelines and are wage adjusted.

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## XV PERSONAL CARE SERVICES

## A. Payment for services

Payment for agency-provided services will be made on a reimbursement basis at an hourly unit rate. Agencies providing personal care services will be licensed home-care agencies. Each agency will submit monthly billings to Aging and Adult Services Administration for personal care services provided in each service area.

Payment for services provided by individual providers will be made directly to the provider via Social Services Payment System. Individual providers of personal care services will be under contract to the department of Social and Health Services.

No payment will be made for services beyond the scope of the program or hours of service exceeding the department's authorization.

## B. Service Rates

The hourly rate for agency provided services is based on the comparable service unit rates. The unit rate for agency-provided personal care increases above household task and chore services due to necessary increased skill levels for home care aides, increased liabilities of provider agencies, and increased administrative costs due to nurse oversight coordination and aide-training activities.

The hourly rate for individual-provided personal care is based on comparable service unit rates. The unit rate for individual-provided personal care services increases above household tasks and chore services rates due to necessary increased skill levels for individual providers of personal care.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Washington

## XVI. Federally Qualified Health Centers

Effective January 1, 2001, the payment methodology for Federally Qualified Health Centers (FQHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all FQHCs that provide services on or after January 1, 2001 and each succeeding year are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an FQHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the center that is at least equal to the PPS payment rate. This alternative methodology must be agreed to by the State and each FQHC, and documentation of each center's agreement must be kept on file by the State. If an individual FQHC does not agree to be reimbursed under this alternative methodology, the FQHC will be paid under the BIPA PPS methodology. Effective for dates of service January 1, 2001 through December 31, 2001, each FQHC agreed to an alternative methodology that provided payments at least equal to the amount the center was entitled to under BIPA PPS. Effective for dates of service on and after January 1, 2002, the State will fully implement the PPS methodology as described in BIPA 2000.

Using the PPS methodology, the payment is set prospectively using a weighted average of 100 percent of the center's total reasonable costs for all Medicaid-covered services as defined in the State Plan for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during calendar year 2001 to establish a base encounter rate. A center may choose to allocate applicable costs and encounters to specific services such as dental, mental health, etc., and establish a separate encounter rate for these services. The encounter rates are determined using each center's audited cost reports and each year's rate is weighted by the total reported encounters. Since the FQHC cost reports are completed using the centers' fiscal years, the cost reports will be adjusted to a calendar year. The formula used to calculate the base encounter rate for a clinic is as follows:

For example, for a center with a Fiscal Year end of March 31:

R = Rate; E = Encounters

$$\text{Base} = \frac{(((\text{FY99R} * \text{FY99E}) / 12) * 3) + (\text{FY00R} * \text{FY00E}) + (((\text{FY01R} * \text{FY01E}) / 12) * 9)}{((\text{FY99E} / 12) * 3) + (\text{FY00E}) + ((\text{FY01E} / 12) * 9)}$$

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State: Washington

## XVI. Federally Qualified Health Centers (Continued)

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service shall occur if: (1) the center adds or drops any service that meets the definition of FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment. The center is responsible for notifying the FQHC Program Manager in writing of any changes during the calendar year no later than 60 days before the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change in scope of service. If the change represents a decrease in scope of service the State will recalculate the base encounter rate by decreasing it by the average cost per encounter detailed in the center's 1999 and 2000 cost reports. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost per encounter as detailed in the 1999 and 2000 cost reports from other centers that provide the service. Once the center can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary and adjust the interim rate by the accepted cost per encounter to establish a final encounter rate. The new encounter rate(s) will be effective on the date the new service was fully implemented and available.

Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the center's scope of services. The MEI for primary care services will be applied to all types of encounter rates established for the center.

FQHCs receiving their initial designation after January 1, 2001 will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar case loads on an interim basis. Within three years of receiving its initial designation, the FQHC must demonstrate its true costs using standard cost reporting methods to establish its base encounter rate. The State will audit the new center's cost report to insure the costs are reasonable and necessary. The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive the MEI increase each year thereafter using the defined methodology. If two or more FQHCs merge after implementation of PPS,

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a weighted average of the centers' encounter rates will be used as the encounter rate for the new center.

For clients enrolled with a managed-care contractor, the State will pay the center a supplemental payment on a per member per month basis, in addition to the amount paid by the managed-care contractor to insure the center is receiving the full amount it is entitled to under the PPS methodology. ~~The supplemental payment will be the average of the center's 1999 and 2000 supplemental payments as established by its audited cost reports. Beginning January 1, 2002 and each year thereafter, the supplemental payment will be increased by the MEI for primary care services.~~

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The supplemental payment is the difference between the payments the center received from the managed-care contractor and the payments the center would have received under the PPS methodology. This supplemental payment will be paid at least every four months.

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Until final audited cost reports for 1999, 2000, and 2001 (if applicable) are available for all FQHCs, and final base encounter rates are established, the centers will be paid using an interim encounter rate comprised of the most current available cost information. The State will perform a reconciliation and settle any overpayments or underpayments made to the centers retroactive to January 1, 2002.

Medicaid-Medicare patients will be reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

## XVI. Medical Services Furnished by a School District

Reimbursement to school districts for medical services provided will be at the usual and customary charges up to a maximum established by the state.

## XVII. Mental Health Services

Each community mental health provider participating in the Medicaid program is required to submit a cost report. These cost reports are aggregated, subjected to statistical tests, and the resulting information is used to determine a cost-based Rate for each provider. These rates are arrayed, from lowest to highest, and statewide maximum rates are set using the 55<sup>th</sup> percentile of provider reported costs. Providers are required to bill their usual and customary charge (UCC) and they are paid at the UCC or the statewide maximum rate, whichever is lower. This process ensures that 100 percent of cost is covered for the most efficient 55 percent of the providers and provides an incentive for higher cost providers to lower their cost of providing service.